

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-002604

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 227 Primary Registration District No. 4339 Registrar's No. 9

FILED FEB 15 1963

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>MONROE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARIS</u>		c. CITY OR TOWN <u>PARIS</u>	
Length of stay in 1b <u>3 YRS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>314 HILL STREET</u>		d. STREET ADDRESS (If outside, give location) <u>314 HILL STREET</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>JOHN THOMAS LOWERY</u>			4. DATE OF DEATH Month <u>FEB.</u> Day <u>9</u> Year <u>1963</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1880</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u>		11. BIRTHPLACE (City and state or country) <u>ILLINOIS</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>JOHN D. LOWERY</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA LOVELACE</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. O. MYRTLE LOWERY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>NO</u>		16. SOCIAL SECURITY NO. <u>61</u>		17. INFORMANT <u>MRS. MYRTLE LOWERY - PARIS, MO</u>	

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) <u>Cerebral Apoplexy</u> Arterio-Sclerosis Interval between ONSET AND DEATH <u>2 days</u> <u>N.K.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II, of item 18.)	
20c. TIME OF INJURY Hour <u>3:30</u> a.m. <u>P</u> Month, Day, Year <u>11-12-46</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>PARIS, MO.</u>		

21. I attended the deceased from <u>11-12-46</u> to <u>2-9-63</u> and last saw him alive on <u>2-9-63</u> Death occurred at <u>3:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>J. A. Barnett, M.D.</u>	22b. ADDRESS <u>Paris, Mo.</u>	22c. DATE SIGNED <u>2/9/1963</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>FEB. 11, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WALNUT GROVE, N.E.M.</u>	23d. LOCATION (City, town, or county) <u>PARIS, MO.</u>
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24. FUNERAL DIRECTOR <u>E. H. AGNEW - PARIS, MO</u>	25. DATE RECD. BY LOCAL REG. <u>2-9-63</u>	26. REGISTRAR'S SIGNATURE <u>J. A. Barnett M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.